STATE OF IDAHO
DEPARTMENT OF INSURANCE
700 WEST STATE STREET, 3rd FLOOR
PO BOX 83720
BOISE, ID 83720-0043

	0560
	1025
FOR DEPARTMENT USE ONLY	1315-10
	TOTAL _____

STATEMENT OF PREMIUM TAXES AND FEES

LIFE, ACCIDENT AND HEALTH COMPANIES

C/A NO.	NAIC NO.

COMPANY NAME	FOR CALENDAR YEAR ENDING DECEMBER 31, 2005
MAILING ADDRESS	DOMICILE STATE

RECAP OF TAXES AND FEES

1. TOTAL TAXES DUE (Page 5, Schedule E, Line 6, GREATER of Column A or Column B) $_____

2. LESS TOTAL PREMIUM TAX CREDITS (Page 4, Schedule D, Line 2) $ N/A

3. LESS 2005 PREPAYMENTS REMITTED: (1) JUNE 15 $_____
(2) SEPT. 15 $_____
(3) DEC. 15 $_____ $_____

4. TAX SUBTOTAL - Line 1 less Lines 2 and 3. If negative amount, also enter on Line 8. $_____

5. ANNUAL CONTINUATION FEE for Calendar Year 2006
MUST ATTACH ANNUAL STATEMENT PAGE 3, LINE 37, used to determine fee amount.

Surplus less than $10,000,000	$1,000.00
Surplus greater than $10,000,000 but less than $100,000,000	$2,500.00
Surplus greater than $100,000,000	$4,500.00

$_____

Payment of continuation fee must be included.
Do not use overpayment of tax on Line 4.

6. PLUS PENALTY, IF DUE ($25.00 per day from postmark delinquency. Idaho Code § 41-404) $_____

7. AMOUNT ENCLOSED – ADD Lines 5 and 6. Include Line 4 if not a negative amount.
Make check payable to: **Idaho Department of Insurance.**
There will be a $20.00 charge on all returned checks. Idaho Code § 28-22-105
Your canceled check is your receipt. $_____

Indicate if payment is by EFT _____

8. REFUND DUE FOR TAX OVERPAYMENT ONLY $_____

Under penalty of perjury, I declare that this statement (including any accompanying schedules and statements) has been examined by me and to the best of my knowledge and belief is a true, correct, and complete statement.

Contact Person

( )
Telephone Number Ext.

Signature of Officer Date

Name and Title (Type or Print)

SCHEDULE A - COMPUTATION OF PREMIUM TAX - LIFE

1. TOTAL LIFE PREMIUMS RECEIVED (including membership and policy fees)
   This amount must agree with the ATTACHED Annual Statement Schedule T and Idaho Business Page. $_____

   A. TOTAL ANNUITY PREMIUMS (For information only) $_____

2. IDAHO DOMESTIC INSURERS - Enter total premiums minus dividends from
   attached SUPPLEMENT 1 - Life Business in Jurisdictions not Licensed $_____

3. LESS POLICY DIVIDENDS & RETURN COUPONS (If allocated as premium payments or
   paid-up additions, amount must be included in premium income shown on Line 1.)
   Cannot exceed the ATTACHED Annual Statement Idaho Business Page or include dividends
   on exempt premiums reported in Line 4. $_____

4. PREMIUMS EXEMPT AND/OR PREEMPTED BY FEDERAL LAW:

TYPE OF PREEMPTION/EXEMPTION	PREMIUMS
A. U.S. INTERNAL REVENUE CODE Sec. 401(a),403,404,408,501(a)	$_____
B._____	$_____
C._____	$_____

   TOTAL EXEMPT PREMIUMS (Add Lines 4A through 4C) $_____

5. NET TAXABLE LIFE PREMIUMS (Line 1 + Line 2 - Line 3 - Line 4) $_____
   Carry forward to Page 5, Schedule E, Line 1, Column A.

6. PREMIUM TAX - 2.5% (1.4%) of Line 5.
   Carry forward to Page 5, Schedule E, Line 1B, Column A.
   If qualified for the 1.4% reduced tax rate under Idaho Code § 41-403,
   you must complete and attach Page 6 and 7, Schedule F. $_____

RETALIATORY SCHEDULE E MUST BE COMPLETED.

⇔COPIES OF THE ANNUAL STATEMENT SCHEDULE T AND IDAHO BUSINESS PAGE MUST BE INCLUDED FOR VERIFICATION.

SCHEDULE B - COMPUTATION OF PREMIUM TAX - ACCIDENT AND HEALTH

1. TOTAL ACCIDENT and HEALTH PREMIUMS (including membership and policy fees).
   This amount must agree with the ATTACHED Annual Statement Schedule T and Idaho Business Page. $_____

2. IDAHO DOMESTIC INSURERS - Enter total premiums minus dividends from
   attached SUPPLEMENT 2 - Accident and Health Business in Jurisdictions not Licensed. $_____

3. LESS DIVIDENDS PAID OR CREDITED ON DIRECT BUSINESS.
   (If allocated as premium payments, amount must be included in
   premium income shown on Line 1). Cannot exceed the ATTACHED Annual Statement Idaho
   Business Page or include dividends on exempt premiums reported in Line 4. $_____

4. PREMIUMS EXEMPT AND/OR PREEMPTED BY FEDERAL LAW:

TYPE OF PREEMPTION/EXEMPTION	PREMIUMS
A. Federal Employers Health Care	$_____
B. _____	$_____
C. _____	$_____

TOTAL EXEMPT PREMIUMS (Add Lines 4A through 4C) $_____

5. NET TAXABLE ACCIDENT AND HEALTH PREMIUMS (Line 1 + Line 2 - Line 3 - Line 4) $_____
   Carry forward to Page 5, Schedule E, Line 2, Column A.

6. PREMIUM TAX - 2.5% (1.4%) of Line 5
   Carry forward to Page 5, Schedule E, Line 2B, Column A.
   If qualified for the 1.4% reduced tax rate under Idaho Code § 41-403,
   you must complete and attach Pages 6 and 7, Schedule F. **$**_____

RETALIATORY SCHEDULE E MUST BE COMPLETED.

⇔COPIES OF THE ANNUAL STATEMENT SCHEDULE T AND IDAHO BUSINESS PAGE MUST BE INCLUDED FOR VERIFICATION.

NAME OF ADMINISTERED PLAN**:** _____

ADDRESS: _____ CITY: _____

NAME OF CONTACT PERSON**:** _____

SCHEDULE C – EACH INDIVIDUAL SELF FUNDED PLANS

NUMBER OF BENEFICIARIES COVERED PER MONTH: Idaho Code § 41-4012

JANUARY	_____	JULY	_____
FEBRUARY	_____	AUGUST	_____
MARCH	_____	SEPTEMBER	_____
APRIL	_____	OCTOBER	_____
MAY	_____	NOVEMBER	_____
JUNE	_____	DECEMBER	_____

TOTAL BENEFICIARIES _____

X $.04 =

TOTAL TAX DUE $_____

ADD each to total reported on Page 5, Column A, Line 5 – OTHER TAXES

SCHEDULE D - TAX CREDITS

IN ORDER TO RECEIVE TAX CREDITS, SCHEDULES MUST BE ATTACHED

1. CLASS B CREDITS
   IDAHO LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION
   $_____N/A_____

2. TOTAL ALLOWABLE IDAHO CREDITS
   Carry Forward to Page 1, Recap of Taxes and Fees, Line 2.
   $_____N/A_____

LINE 2 CANNOT EXCEED THE TOTAL PREMIUM TAX LIABILITY
Page 5, Schedule E, Line 6, Column A or B, whichever is greater.

SCHEDULE E - COMPUTATION OF RETALIATORY TAXES

Idaho Code § 41-340 (2) and (3)

NET PREMIUMS SUBJECT TO TAX:	Column A AMOUNT PAID IN IDAHO	Column B AMOUNT WOULD PAY IN DOMICILE STATE
1. LIFE PREMIUMS	$_____	$_____
A. PREMIUM TAX RATE	2.5% or 1.4%	_____
B. PREMIUM TAX (Line 1 x Line 1A)	$_____	$_____
2. ACCIDENT AND HEALTH PREMIUMS	$_____	$_____
A. PREMIUM TAX RATE	2.5% or 1.4%	_____
B. PREMIUM TAX (Line 2 x Line 2A)	$_____	$_____
3. ANNUITY PREMIUMS	XXXXXXXXXXXXXXXXXXXX	$_____
A. ANNUITY TAX RATE	XXXXXXXXXXXXXXXXXXXX	_____
B. ANNUITY TAX (Line 3 x Line 3A)	XXXXXXXXXXXXXXXXXXXX	$_____
4. MUNICIPAL, CITY OR COUNTY PREMIUMS	XXXXXXXXXXXXXXXXXXXX	$_____
A. MUNICIPAL, CITY OR COUNTY TAX RATE	XXXXXXXXXXXXXXXXXXXX	_____
B. MUNICIPAL, CITY OR COUNTY TAX (Line 4 x Line 4A)	XXXXXXXXXXXXXXXXXXXX	$_____
5. OTHER TAXES - Identify Each:		
SELF-FUNDED PLANS (Schedule C)	$_____	$_____
_____	$_____	$_____
6. TOTAL TAXES (Lines 1B+2B+3B+4B+5) Carry GREATER AMOUNT of Column A or B forward to Page 1, Recap of Taxes, Line 1	**$**_____	$_____

SCHEDULE F - QUALIFICATION FOR REDUCED PREMIUM TAX

Idaho Code § 41-403

Complete, sign and attach, only if you are requesting the reduced tax rate on Pages 2 or 3.

An itemized schedule MUST BE ATTACHED showing qualified investment descriptions, amounts, types, inception and maturity dates for each Idaho investment; and must agree with amounts reported on Annual Statement, Page 2 as Net Admitted Assets in Column 3 .

Reduced Tax Qualification for Year Ending December 31, 2005

Public Obligations	$ _____
Corporate Bonds	$ _____
Preferred Stock	$ _____
Common Stock	$ _____
Mortgage Loans	$ _____
Real Estate	$ _____
Time Deposits	$ _____
Other (Explain)_____	$ _____
TOTAL QUALIFYING IDAHO INVESTMENTS	$ _____
IF licensed for LIFE: Enter Total Required Reserves (ATTACH Annual Statement, Page 3, Column 1, Line 1 + Line 2)	$ _____
Percentage of Qualifying Idaho Investments to Required Reserves	_____%

** OR **

IF licensed for OTHER THAN LIFE: Enter Total Net Admitted Assets (ATTACH Annual Statement, Page 2, Column 3, Line 26)	$ _____
Percentage of Qualifying Idaho Investments to Admitted Assets	_____%

NOTE: Qualification for the reduced premium tax rate (1.4% or retaliatory rate, whichever is greater) shall be in strict conformity with the provisions of Idaho Code § 41-403, and the computation for qualification made hereon shall be subject to examination and review by the Department of Insurance.

I hereby certify that the investments listed herein are qualifying Idaho investments as provided by Idaho Code § 41-403, and that the company, as shown above, has qualified at all times throughout the year for the reduced premium tax rate.

_____ Date

_____ Signature

_____ Name and Title (Type or print)

MONTHLY TOTALS REQUIRED FOR QUALIFYING IDAHO INVESTMENTS

	TOTAL REQUIRED RESERVES OR ADMITTED ASSETS	TOTAL QUALIFIED IDAHO INVESTMENTS	PERCENTAGE RATIO
Per Annual Statement Prior Year's Balance December 31, 2004	$_____	$_____	_____
January	$_____	$_____	_____
February	$_____	$_____	_____
March	$_____	$_____	_____
April	$_____	$_____	_____
May	$_____	$_____	_____
June	$_____	$_____	_____
July	$_____	$_____	_____
August	$_____	$_____	_____
September	$_____	$_____	_____
October	$_____	$_____	_____
November	$_____	$_____	_____
December 31, 2005	$_____	$_____	_____